



Application for ADA Para-transit Service (Handi-Wheels)

Complete application and return to:

City of Jefferson / Transit Division
820 E. Miller Street, Jefferson City, Mo. 65101
(573) 634-6477

TRANSIT DEPARTMENT USE ONLY

____ NEW APPLICATION

____ RENEWAL APPLICATION

CARD # _____

DATE ISSUED _____

EXPIRATION DATE _____

ELIGIBILITY CODE _____

INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

Last Name _____ First Name _____ Middle _____

Address _____ City _____ Zip _____

Date of Birth (month/day/year) ____ / ____ / ____

☐

Male

☐

Female

Daytime Phone: _____ Cellular Phone: _____ Evening Phone: _____

Email address: _____ Social Security Number: _____

MoHealthNet Card #: _____

In the event of a situation requiring outside assistance or a medical emergency, who in the local area should be contacted?

Emergency Contact Name: _____ Relationship: _____

Daytime Phone: _____ Cellular Phone: _____

I. MOBILITY INFORMATION

1. Which of the following mobility aids or equipment do you use to help you get where you need to go? *(Please check ALL that apply to you)*

___ None

___ Manual Wheelchair

___ Service Animal

___ Cane

___ Power Wheelchair

___ Picture Board

___ White Cane

___ Power Scooter/Cart

___ Alphabet Board

___ Walker

___ Portable Oxygen

___ Crutches

___ Other _____

2. If you use a wheelchair or scooter/cart, what are the physical dimensions of the chair, including foot and head extensions (in inches)? _____ Wide _____ High _____ Length

NOTE: Maximum weight the bus lift will hold safely is 600 pounds.

Maximum dimensions 32" Width 48" Length 56" Height

Revised

04/01/2015

3. Using a mobility aid or on your own, how many blocks (500 feet) can you travel on level ground?
☐ None ☐ Less than 2 blocks ☐ 2 to 4 blocks ☐ more than 4 blocks
4. If you were to ride the Fixed Route buses would you need an assistant with you?
☐ Always
☐ Sometimes
☐ No
5. Have you received training on how to use the fixed route bus?
☐ Yes
☐ Yes, but I'd like to attend training again
☐ No Would you be interested in attending a training session? ☐ Yes ☐ No

II. DISABILITY OR HEALTH CONDITION INFORMATION

(Please indicate all conditions which affect your ability to use the bus)

1. The disability that prevents me from using the regular fixed route buses would place me in the following category:
- ☐ I am unable to ride the JEFFTRAN bus without the assistance of someone else.
☐ The bus stop is not accessible due to lack of sidewalks or curb cuts.
☐ My disability prevents me from getting to and from the bus stop.
☐ My disability does not prevent me from riding the JEFFTRAN bus.

2. Disabling Condition(s)

3. Please explain how your disability prevents you from using the JEFFTRAN fixed route bus system.

Be specific. (Attach any additional information, if necessary)

Is this condition temporary ☐ Yes ☐ No ☐ Not sure

If Yes, expected duration until ____/____/____

III. Please mark all the categories below as they relate to your disability

1. Do you currently ride the regular JEFFTRAN fixed route bus
____ Yes How many days per week? _____
____ No
2. Are you able to independently maneuver on or off a wheelchair lift?
____ Yes ____ No ____ N/A
3. Are you able to identify the correct bus?
____ Yes
____ No Please explain _____
4. Can you communicate with a bus driver yourself or with the help of an aid (such as a letter board)
____ Yes ____ No
5. How many blocks from your residence is the nearest JEFFTRAN bus stop?
____ Less than 2 ____ 2 to 4 ____ More than 4 ____ Don't know
6. How long are you able to wait for a bus at a bus stop? _____ minutes
7. Are you able to step up and down or climb 10-inch steps independently?
____ Yes ____ No
8. Do changes in weather (extreme heat, cold, wind, rain snow or ice) prevent you from getting around on your own?
____ Yes Please describe _____
____ No _____
9. Do you have limited vision?
____ Yes ____ No
10. Are you legally blind (Legally blind is defined as: The vision acuity in your best eye with the best correction is no better than 20/200, or the vision field of the best eye is constricted to less than 20 degrees.)
____ Yes ____ No Visual Acuity: _____ Right eye _____ Left eye
11. Are you able to handle/grasp coins (pay fare), tickets, railings and handles?
____ Yes ____ No Please explain _____
12. Are you able to keep your balance while seated on a moving vehicle?
____ Yes ____ No Please explain _____
13. Are you able to read, hear, understand and/or process information, schedules or directions which are needed to make necessary decisions during a trip?
____ Yes ____ No Please explain _____
14. Are you able to give address and telephone numbers upon request?
____ Yes ____ No

15. Please answer the following questions.

Indicate if you walk or use a mobility aid: Walk_____ Mobility Aid_____

Can you travel 200 feet without assistance from another person?

Yes_____ No_____ Sometimes_____

Can you travel 1/4 mile without assistance from another person?

Yes_____ No_____ Sometimes_____

Can you travel 3/4 mile without assistance from another person?

Yes_____ No_____ Sometimes_____

Can you climb three 12 inch steps without handrails or assistance?

Yes_____ No_____ Sometimes_____

If you use a wheelchair or power scooter, can you use the wheelchair ramp to board a fixed route bus?

Yes_____ No_____

Can you wait at a bus stop, without support, for ten minutes?

Yes_____ No_____ Sometimes_____

Can you communicate with a bus driver yourself or with the help of an aid(such as a letter board)?

Yes_____ No_____ Sometimes_____

Applicant Signature

I certify the information I have provided in this application is true and correct. I understand falsification of information may result in denial of service. I understand this application will be kept confidential, and only the information required to provide the services I requested will be disclosed to those who perform those services. I understand JEFFTRAN may contact the health care professional who has completed the Professional Verification Form attached to this application, in order to confirm this information.

Applicant's Signature_____

Date_____

Person completing form if other than applicant (please check one):

_____ I certify the information provided in this application is true and correct based upon information given me by the applicant.

_____ I certify the information provided in this application is true and correct based upon my own knowledge of the applicant's health condition or disability.

Exceptions or Additions:

Print Name _____

Relationship to Applicant _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Daytime Phone _____ Signature _____

***PROFESSIONAL VERIFICATION FOR _____**

Patient's Name

***NOTE: THIS PORTION MUST BE COMPLETED BY ONE OF THE FOLLOWING RECOGNIZED PROFESSIONALS:** registered nurse, physician, social worker, psychologist, physical therapist, chiropractor, occupational therapist, speech pathologist, nurse practitioner, physician's assistant, mental health counselor, respiratory therapist, vocational rehabilitation counselor, or recreation therapist employed by a medical facility.

This verification will assist in determining if applicant is unable to ride the regular fixed route bus system and therefore eligible for Handi-Wheels Paratransit (ADA Disabled) bus service for all or some trip requests based upon his/her functional ability.

Note: All JEFFTRAN's regular fixed route buses are low-floor buses equipped with ramps to accommodate persons with wheelchairs or those who cannot climb stairs. The definition of a fixed route bus is a bus that travels on a fixed route with a set time schedule. Whereas, Handi-Wheels buses are smaller buses that are equipped with a wheelchair lift that transports only those passengers that are ADA disabled and unable to ride the fixed route bus system. Handi-Wheels bus service requires reservations and is operated on a demand-responsive, origin-to-destination basis with the basic mode being curb-to-curb service.

All information will be kept confidential. Thank you for your assistance.

Capacity in which you know the applicant: _____

Is applicant able to travel on a fixed route bus that is wheelchair accessible?

___ YES, Fixed Route Bus ___ NO*, Handi-Wheels Bus

If no, what is the functional impairment that would prevent applicant from traveling on the fixed route bus?

Is applicant able to get to or from the bus stop with any type of mobility aid? ___ YES ___ NO*

*If no, what is the functional impairment? _____

Is this condition temporary? ___ NO ___ YES, for _____ months

___ I have reviewed all of the information contained in this application, and hereby certify that all information is true and correct to the best of my knowledge and ability.

Please provide additional information to help us determine eligibility:

Print Name and Title: _____

Signature _____

Date _____

Clinic/Agency _____

Phone/Fax: _____

Address _____

City/State/Zip: _____

State License Number _____

Revised

04/01/2015